EXHIBIT A

AFFIDAVIT

STATE OF ALABAMA)
Barbour COUNTY)

I, Dorothy Stanford, hereby certify and affirm that I am a Medical Records Clerk, at Ventress Correctional Facility; that I am one of the custodians of medical records at this institution; that the attached documents are true, exact, and correct photocopies of certain medical records maintained here in the institution medical file of one Willie Strickland, AIS# 226537; and that I am over the age of twenty-one years and am competent to testify to the aforesaid documents and matters stated therein.

I further certify and affirm that said documents are maintained in the usual and ordinary course of business at Ventress Correctional; and that said documents (and the entries therein) were made at, or reasonably near, the time that by, or from information transmitted by, a person with knowledge of such acts, events, and transactions referred to therein are said to have occurred.

This, I do hereby certify and affirm to on this the 14th day of October, 2005.

Dorothy Stanford

SWORN TO AND SUBSCRIBED BEFORE ME THIS THE 14th Day of October, 2005.

Reba J Currie
Notary Public
5-8-08
My Commission Expires

PROBLEM LIST

Name: Strickland, Willie

AIS# 226537

Date of Birth: [redacted]

Medication Allergies: NKDA

Mental Health Code: SMI HARM HIST NONE Date Code Assigned: 1/21/03
(Changes in Mental Health Code should be identified on the Problem List)

Date Identified	Chronic (Long-Term) Problems Roman Numerals for Medical/Surgical Capital Letters for Psychiatric/Behavioral	Date Resolved	Health Care Practitioner Initial
1/23/03	Impulse Disorder NOS -	09-09-03	[illegible]
1/23/03	Rx Cocaine Abuse		[illegible] MD.
1/30/03	- Cannot hear -		
8/21/03	Headache / Dizziness		
9/4/03	Migraine Headache.		Cooley Crum
9-9-03	HIST	9-9-03	WCC
7/21/00	RIH		

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PRISON HEALTH SERVICES, INC.

YEARLY HEALTH EVALUATION

I. HISTORY – (LPN or RN)	YES	NO	COMMENT(S)
Weight Change (greater 15 lbs.) (Compare Weight Below)		✓	188# Last weight at least 6 months ago
Persistent Cough		✓	
Chest Pain		✓	
Blood in Urine or Stool		✓	
Difficult Urination		✓	
Other Illnesses (Details)		✓	
Smoke, Dip or Chew	✓		1 can q 3 days
ALLERGIES		✓	

Weight 192.5 Temp 99.8 Height 6'0" Pulse 83 Resp 16 Blood Pressure 112/68

If greater than > 140/90, repeat in 1hour. Refer to M.D. if remains > 140/90.

Eye Exam: 20/20 OD 20/20 OS 20/20 OU

II. TESTING – (LPN or RN)	RESULTS
Tuberculin Skin Test (q yr)	Date given 4-8-05 Site LFA Read on 4.10.05 Results 0 mm
Past Positive TB Skin Test →	**Survey Completed** N/A
(Chest x-ray if clinical symptoms)	Date — Results —
RPR (q 3 yrs)	Date 1-21-03 Results NR
EKG (baseline at 35, over 45 q 3 yrs)	11-12-03
Cholesterol (at 35 then q 5 yrs)	NA
Tetanus/Diptheria (q 10 yrs) (if done today)	Last Given 2001 Due 2011 Site given — Dose — Lot # —
Optometry Exam (@ 50 if not already seen)	NA
Mammogram (females @ 40, q 2 yrs/other M.D. order)	Date NA Results —

III. PHYSICAL RESULTS – (RN, Mid-Level, M.D.)

Class (1) 2 3 4 5 Restrictions None

Heart RRR

Lungs clear bilateral

Breast Exam Okay

Rectal (yearly after 45) Results NA

with Hemoccult Results —

Pelvic and PAP (q 1 yr) Date NA Results —

Facility Ventress Nurse Signature [signature] Date 4-8-05

M.D. or Mid-Level Signature [signature] Date 4/12/05

INMATE NAME	AIS#	D.O.B.	RACE/SEX
Strickland, Willie	226537	[redacted]	W/M

PRISON HEALTH SERVICES, INC.

DEPARTMENT OF CORRECTIONS

NOTIFICATION OF NEXT OF KIN

In the event of a serious injury or illness, I request the following person be notified:

Brenda Strickland — mother
Name — **Relationship**

4165 County Road 299 — (334) 749-9393
Street Address — **Phone Number**

Dozier Cusseta, — Al — 36852
City — **State** — **Zip Code**

Willie Strickland — 226537 — [redacted] — 4-08-05
Inmate Signature — **AIS#** — **SS#** — **Date**

R. Hice, Lpn — 4-8-05
Witness — **Date**

INMATE NAME (LAST, FIRST, MIDDLE)	AIS#	D.O.B.	RACE/SEX	FACILITY
Strickland, Willie	226537	[redacted]	W/M	VCF

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Strickland Willie
LAST FIRST MI

DATE OF BIRTH [redacted] A15 SS# 226537

Housing Recommendations:

General Population____ Trust - 6 month
Medical Observation Unit____
Lower Level/Lower Bunk____
Suicide Precautions____ LTC - 6 mo fu
Special Watch (15 Minute Checks)____ F/U.
Isolation____ 8-28-05
Initiate Universal Precautions____

Individual found to be:

Frail/Elderly____
Physically Handicapped____
Developmentally Disabled____
Drug/Alcohol Withdrawal____
Special Mental Health Needs____
Expressed Suicidal Ideation____
History of Seizures____
Other____

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Specify_____

Nurse [signature] RN Date 2/22/05

GLF 1005 Original/Classification Second Copy/Booking Staff Third Copy/Medical Unit

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Strickland, Willie
LAST FIRST MI

DATE OF BIRTH [redacted] SS# _____

Housing Recommendations:

General Population____ TO HCU on Mon.
Medical Observation Unit____ 6/14 @ 9Am for
Lower Level/Lower Bunk____ Apt with MD.
Suicide Precautions____
Special Watch (15 Minute Checks)____
Isolation____
Initiate Universal Precautions____

Individual found to be:

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Frail/Elderly____
Physically Handicapped____
Developmentally Disabled____
Drug/Alcohol Withdrawal____
Special Mental Health Needs____
Expressed Suicidal Ideation____
History of Seizures____
Other____
Specify_____

Nurse [signature] Date 6/10/04

Willie Strickland

GLF 1005 Original/Classification Second Copy/Booking Staff Third Copy/Medical Unit

PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

NOTIFICATION OF NEXT OF KIN

In the event of a serious injury or illness, I request the following person be notified:

Brenda Strickland — Name
Mother — Relationship

4165 CTy Rd. 299 — Street Address
334-749-9393 — Phone Number

Cusseta — City
Al. — State
36852 — Zip Code

Willie Strickland — Inmate Signature
226537 — Doc#
[redacted] — S.S.#
3/23/04 — Date

B Benefield — Witness
3-23-04 — Date

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INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	RACE/SEX	FAC.
Strickland, Willie	226537	[redacted]	WM	VCF

PHS-MD-70003 (White – Medical Record, Yellow – Active File, Pink – Control Center)

3-79 T

HEALTH EVALUATION

Age Sex Race Ht Wt

Strickland, Willie 226537

Temp	P	Pulse	Resp
98.8	110 / 60	68	20

Do you now or have you ever had, or been treated for:

Problems	Y	N	Problems	Y	N
Head Trauma		✓	Kidney Stones/Disease		✓
Loss of Consciousness		✓	Bladder/Kidney Infection		✓
Severe Headaches		✓	Alcoholism		✓
Vertigo/Dizziness		✓	Drug Abuse	✓	
Vision Problems	✓		Tobacco Use	✓	
Hearing Problems	✓		Psychiatric Hx		✓
Dental Prob / Dentures	✓		Suicidal		✓
Seizures		✓	**Communicable/Contagious**		
Strokes		✓	Tuberculosis		✓
Nervous Disorders		✓	HIV/ AIDS		✓
DT's		✓	Hepatitis- Type		✓
Heart Condition		✓	Gonorrhea		✓
Angina/Heart Attack		✓	Syphilis		✓
High B.P.		✓	Lice; Crabs; Scabies		✓
Anemia/Blood		✓	**OB/ GYN**		
Lung Condition		✓	LMP Date:		
Asthma		✓	Duration:		
Bronchitis		✓	LMP Normal:		
Emphysema		✓	Regularity:	Y	N
Pneumonia		✓	Gravida/Para:		
Diabetes		✓	AB/Miscarriage:		
Hay Fever/ Allergies		✓	Contraception:	Y	N
Gastritis		✓	Describe:		
Ulcers		✓	LAB Tests- Dates	N	Ab
Bleeding		✓	RPR 1-21-03	✓	
Gall Bladder/Pancreas		✓	PPD- Date given: 3-23-04		
Liver Problems		✓	RFA/ LFA RFA		
Arthritis		✓	Date read: 3-25-04		
Joint Muscle Problem		✓	Results in mm.: 0		
Back/Neck Problem	✓		Deferred/Follow-up: Dental		

APPRAISAL		N	Abn/Comment
	Screening Observation	☐	Check items below & initial
General	Movement, Deformity, Pain, Bleeding, Habitus, Hygiene	☒ BL	C/O Stiff neck @ X's
Neuro	Mental Status, Intox Withdrawal, Tremors, Neuro-deficits	☒ BL	
Skin	Injury, Bruises, Trauma, Jaundice, Diaphoretic, Rash, Lesions, Infestations, Needle Marks, Color, Turgor	☐ BL	Holes through both nipples
Head	Normocephalic, Atraumatic, Hair, Scalp	☒ BL	
Eyes	Glasses/ Vision, Pupils, Sclera, Conjunctiva	☒ BL	
Ears	Appearance, Canals, (TM's), (Hearing) — TM (L) Brown	☒ BL	C/O decreased (L) ear hearing
Nose	Epistaxsis, Sinuses	☒ BL	
Throat	Teeth, Gums, Dentures, (Mouth), Tongue, Tonsils, Airway	☐ BL	Decayed teeth, white patch (R) inside cheeks
Neck	C Spine, Mobility, Veins, Carotids, Thyroid, Lymph Nodes	☒ BL	
Chest	Config. Ausc./ Resp., Cough/ Sputum, (Breasts) Masses	☐ BL	Holes through both nipples
Heart	Ausc. Rate, Rhythm, Murmurs, Ectopy	☒ BL	
Abdomen	Bowel Sounds, Palp, G/R/T, Hernia	☒ BL	
GU	Flank Tenderness, Bladder Tenderness /Distention	☒ BL	
Back	ROM, Spasm, Injury	☒ BL	
Extrem	Edema, Pulse, Cyanosis- ROM, Injury	☒ BL	
Genitals	Injuries/ Lesions	☒	Denied-not viewed
Pelvic/ Pap	Deferred ☐		
Rectal/ Guiac	Deferred ☒		
	(1)		

Comments:

Placement: (✓) General Population ( ) Emergency Dept ( ) Isolation ( ) Medical Observation ( ) Other: ______
Referral: ( ) Medical (✓) Dental ( ) Mental Health ( ) Other ______ When: ( ) Immediately ( ) Next Sick Call ______

M Benefield 3/23/04 1045 — Screener's Signature — Date/Time

C Oakley Ch — Evaluator's Signature/ Title — 3/31/04 — Date/ Time

B. Lute RN 3-23-04

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Stickland Willie
LAST FIRST MI

DATE OF BIRTH [redacted] SS# 226537

Housing Recommendations:

General Population____ (D No heavy lifting greater than 15/25 from 8-25-05 till 2-25-06

Medical Observation Unit____

Lower Level/Lower Bunk____

Suicide Precautions____

Special Watch (15 Minute Checks)____

Isolation____

Initiate Universal Precautions____

Individual found to be:

Frail/Elderly____

Physically Handicapped____

Developmentally Disabled____

Drug/Alcohol Withdrawal____

Special Mental Health Needs____

Expressed Suicidal Ideation____

History of Seizures____

Other____

Specify____ Willie Stickland

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Nurse A Mark Date 8-25-05

GLF 1005 Original/Classification Second Copy/Booking Staff Third Copy/Medical Unit

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Strickland, Willie
LAST FIRST MI

DATE OF BIRTH [redacted] **SS#** 226537

Housing Recommendations:

General Population____
Medical Observation Unit____
Lower Level/Lower Bunk X
Suicide Precautions____
Special Watch (15 Minute Checks)____
Isolation____
Initiate Universal Precautions____

BB x 6 mos. (7.21.05 → 1.21.06)

Individual found to be:

Frail/Elderly____
Physically Handicapped____
Developmentally Disabled____
Drug/Alcohol Withdrawal____
Special Mental Health Needs____
Expressed Suicidal Ideation____
History of Seizures____
Other____

Specify____

* Hernia truss x 6 mos. (7-21-05 → 1-21-06)

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Nurse [signature] Date 7.21.05

Willie Strickland

GLF 1005 Original/Classification Second Copy/Booking Staff Third Copy/Medical Unit

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Strickland Willie #226537
LAST FIRST MI

DATE OF BIRTH [redacted] **SS#** [redacted]

Housing Recommendations:

General Population X

Medical Observation Unit_____

Lower Level/Lower Bunk X

Suicide Precautions_____

Special Watch (15 Minute Checks)_____

Isolation_____

Initiate Universal Precautions_____

Individual found to be: BBP 7/18/05 - 7/21/05

Frail/Elderly_____

Physically Handicapped_____

Developmentally Disabled_____

Drug/Alcohol Withdrawal_____

Special Mental Health Needs____

Expressed Suicidal Ideation_____

History of Seizures_____

Other X Risk for injury

Specify_____

Nurse D. Williams, RN Date 7-18-05

Willie Strickland 226537

PHS
PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Willie Strickland (Print Name) 3-2-05 (Doc#)

acknowledge receipt of the following medical equipment or appliance:

( ) Splint
( ) Eyeglasses
( ) Dentures
( ) Prothesis describe _____
( ) Wheelchair
( ) Cane
( ) Crutches
(X) Other describe Inguinal Hernia Aid

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I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

X Willie Strickland (Inmate) X 3-2-05 (Date)

M Benefield Jr (Witness) 3-2-05 (Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC
Strickland, Willie	226537	[redacted]	W/M	VCF

PHS-MD-70005 (White – Medical File, Yellow – Security Property Officer)

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Strickland Willie - 226537
LAST FIRST MI

DATE OF BIRTH [redacted] SS# _____

Housing Recommendations:

General Population____
Medical Observation Unit____ Report to
Lower Level/Lower Bunk____ HCU @ 8 AM
Suicide Precautions____
Special Watch (15 Minute Checks)____ on Feb. 20th
Isolation____
Initiate Universal Precautions____ for apt with MD

Individual found to be:

Frail/Elderly____
Physically Handicapped____
Developmentally Disabled____
Drug/Alcohol Withdrawal____
Special Mental Health Needs____
Expressed Suicidal Ideation____
History of Seizures____
Other____
Specify_____

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Nurse [signature] Date 2-10-05

Willie Strickland 226537

GLE 1005 Original/Classification Second Copy/Booking Staff Third Copy/Medical Unit

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Strickland, Willie
LAST FIRST MI

DATE OF BIRTH [redacted] SS# 226537

Housing Recommendations:

General Population_____
Medical Observation Unit_____
Lower Level/Lower Bunk_____ Bottom Bunk
Suicide Precautions_____
Special Watch (15 Minute Checks)_____ Profile X
Isolation_____ 60ys
Initiate Universal Precautions_____ 11-24-04 — 11-30-04

Individual found to be:

Frail/Elderly_____
Physically Handicapped_____
Developmentally Disabled_____
Drug/Alcohol Withdrawal_____
Special Mental Health Needs_____ Willie Strickland
Expressed Suicidal Ideation_____
History of Seizures_____
Other_____
Specify_____

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Nurse [signature] Date 11-24-04

Original/Classification Second Copy/Booking Staff Third Copy/Medical Unit

Warden Giles 04

I am writing this letter because I am concerned about the medical condition of my son, Willie Strickland. 226537
He has a hernia and has been hurting for approx. 2 months. He has been to the Doctor 3 times. All the Doctor has done is to give him a Truss which is not helping. He has been to HCU 6 times. A hernia does not go away by itself. He is in pain and we want to know what steps we need to take to get him the proper medical treatment he needs which will more than likely be surgery. We have tried numerous times to reach you by phone regarding this matter but for one reason or another haven't been able to talk to you. This is a serious matter that needs your immediate attention. You can contact me at 334-749-9393 or 4165 Co. Rd. 299 Cusseta, al 36852. We would appreciate a quick response from you regarding this matter.

Sincerely, Brenda Strickland

To: Warden Giles
From: N. Burks
Date: 6/8/04
Ref: Strickland, Willie

Inmate Strickland, Willie 226537 turned in a sick call request dated 5/5/04, complaining of "severe abdominal pain on right side". Was seen at sick call on 5/6/04 and referred to M. D. Appointment given for 5/7/04. Dr Rayapati's assessment, wants bottom bunk, abdominal non-tender. Bottom bunk profile denied.

On 5/14/04, Strickland put in another sick call request, complaining of "pain in right of stomach beside groin area". He was seen at sick call on 5/14. Appointment given to see M.D.on 5/17/04. Dr Rayapati's assessment, reducible non tenderness over pubic area no redness or swelling.
questionable prodroma hernia. Malingering for bottom bunk. Truss ordered.

On 6/3/04, I spoke to inmate per his request in reference to above complaints. I gave Strickland another appointment to see M.D. for further evaluation on 6/3/04. He was Diagnosed with right inguinal hernia, given a lay in profile.

I will speak with Dr Raypati this week in reference to referring Strickland to Dr Whyte for a surgical evaluation.

N Burks, RN, H. S. A.

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Strickland, Willie
LAST FIRST MI

DATE OF BIRTH [redacted] SS# _____

Housing Recommendations:

General Population____
Medical Observation Unit____
Lower Level/Lower Bunk____
Suicide Precautions____
Special Watch (15 Minute Checks)____
Isolation____
Initiate Universal Precautions____

Lay in Profile X 6 months 6/3/04 - 12/3/04

Individual found to be:

Frail/Elderly____
Physically Handicapped____
Developmentally Disabled____
Drug/Alcohol Withdrawal____
Special Mental Health Needs____
Expressed Suicidal Ideation____
History of Seizures____
Other____

Specify_____

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Nurse J. Smith LPN Date 6/3/04

+ Willie Strickland 226037

GLF 1005 Original/Classification Second Copy/Booking Staff Third Copy/Medical Unit

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Strickland Willie
LAST **FIRST** **MI**

DATE OF BIRTH [redacted] **SS#** _____

Housing Recommendations:

To HCU @ 8:30 on 6/3 for MD apt.
N. Burkhalter

General Population____

Medical Observation Unit____

Lower Level/Lower Bunk____

Suicide Precautions____

Special Watch (15 Minute Checks)____

Isolation____

Initiate Universal Precautions____

Individual found to be:

Frail/Elderly____

Physically Handicapped____

Developmentally Disabled____

Drug/Alcohol Withdrawal____

Special Mental Health Needs____

Expressed Suicidal Ideation____

History of Seizures____

Other____

Specify_____

Nurse N. Burkhalter Date 6/2/04

Willie Strickland

GLE 1005 Original/Classification Second Copy/Booking Staff Third Copy/Medical Unit

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Strickland, William
LAST **FIRST** **MI**

DATE OF BIRTH [redacted] **SS#** [redacted]

AIS# 226537

Housing Recommendations:

General Population____
Medical Observation Unit____
Lower Level/Lower Bunk____
Suicide Precautions____
Special Watch (15 Minute Checks)____
Isolation____
Initiate Universal Precautions____

Druss for RIH
X6 (six) months
5/17/04 – 11/17/04

Individual found to be:

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Frail/Elderly____
Physically Handicapped____
Developmentally Disabled____
Drug/Alcohol Withdrawal____
Special Mental Health Needs____
Expressed Suicidal Ideation____
History of Seizures____
Other____
Specify____

Nurse G Johnson LPN Date 5/17/04

William Strickland 226537

CLE 1095 Original/Classification Second Copy/Booking Staff Third Copy/Medical Unit

IDENTIFICATION OF SPECIAL NEEDS

NAME (PLEASE PRINT) Strickland, Willie
LAST **FIRST** **MI**

DATE OF BIRTH [redacted] **SS#** [redacted]

A15# 226537

Housing Recommendations:

General Population____
Medical Observation Unit____
Lower Level/Lower Bunk____
Suicide Precautions____
Special Watch (15 Minute Checks)____
Isolation____
Initiate Universal Precautions____

Return to HCU when Rt groin area starts to swell so nurses can observe and make notation in chart.

Individual found to be:

Frail/Elderly____
Physically Handicapped____
Developmentally Disabled____
Drug/Alcohol Withdrawal____
Special Mental Health Needs____
Expressed Suicidal Ideation____
History of Seizures____
Other____
Specify____

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Nurse J Johnson RN Date 5/17/04

Willie Strickland 226507

CLF-1006 Original/Classification Second Copy/Booking Staff Third Copy/Medical Unit

PHS
PRISON HEALTH SERVICES INCORPORATED

EMERGENCY

ADMISSION DATE 5/10/04 TIME 9:30 AM PM
ORIGINATING FACILITY Ventress ☐ SIR ☐ PDL ☐ ESCAPEE ☐
☐ SICK CALL ☐ EMERGENCY ☐ OUTPATIENT

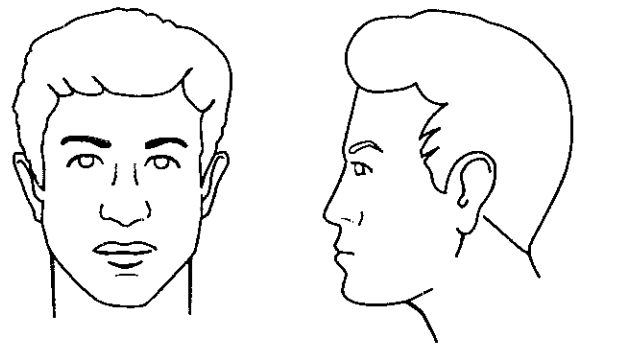
ALLERGIES NKDA wt 190#
CONDITION ON ADMISSION ☐ GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA

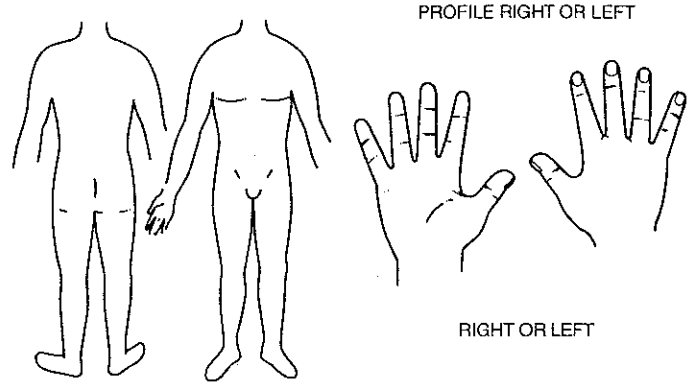
VITAL SIGNS: TEMP 99.6 ORAL RECTAL RESP 18 PULSE 80 B/P 112/82 RECHECK IF SYSTOLIC <100> 50 /

NATURE OF INJURY OR ILLNESS

S- I've been hurting right between my legs I saw the doctor but he said he didn't find anything, but it hurts

ABRASION /// CONTUSION # BURN XX XX FRACTURE Z Z LACERATION / ____ SUTURES


PROFILE RIGHT OR LEFT


RIGHT OR LEFT

PHYSICAL EXAMINATION

O- WM Alert & oriented x3. Skin warm dry. Tenderness to palpation upon palpation of R groin. No redness or edema noted.

A- alteration in comfort

P- Motrin 600mg PO TID x 3 days

ORDERS / MEDICATIONS / IV FLUIDS | TIME | BY

DIAGNOSIS

INSTRUCTIONS TO PATIENT Sick call if pain increases or if condition worsens.

DISCHARGE DATE 5/10/04 TIME 9:37 AM PM
RELEASE / TRANSFERRED TO ☐ DOC ☑ AMBULANCE ☐
CONDITION ON DISCHARGE ☑ SATISFACTORY ☐ POOR ☐ FAIR ☐ CRITICAL

NURSE'S SIGNATURE [signature] DATE 5-10-04
PHYSICIAN'S SIGNATURE [signature] DATE
CONSULTATION

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC
Strickland, Willie	226537	[redacted]	WM	VCF

PHS
PRISON HEALTH SERVICES INCORPORATED

RELEASE OF RESPONSIBILITY

Inmate's Name: Willie Strickland

Date of Birth: [redacted] Social Security No: AIS# 2265375

Date: 12-31-03 Time: 8:37 A.M. (P.M.)

This is to certify that I, Willie Strickland (Print Inmate's Name), currently in

custody at the VCF (Print Facility's Name), am refusing to

accept the following treatment/recommendations: Sick Call on 12-31-03 (Specify in Detail)

I acknowledge that I have been fully informed of and understand the above treatment(s)/recommendation(s) and the risks involved in refusing them. I hereby release and agree to hold harmless the City/County/State, statutory authority, all correctional personnel, Prison Health Services, Inc and all medical personnel from all responsibility and liabilities which may result from this action/refusal and I personally assume all responsibility for my welfare.

Willie Strickland (Signature of Inmate)**

(Signature of Medical Person)

(Witness)

(Witness)

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

PHS
PRISON HEALTH SERVICES INCORPORATED

PHYSICIANS' ORDERS

NAME: D.O.B / / ALLERGIES: Use Last Date / /	DIAGNOSIS (If Chg'd) ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Fourth Date / /	DIAGNOSIS (If Chg'd) ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: D.O.B. / / ALLERGIES: Use Third Date / /	DIAGNOSIS (If Chg'd) FOR PROFESSIONAL USE ONLY CONFIDENTIAL RECORD NOT TO BE PHOTO COPIED ☐ GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Strickland Willie 226537 D.O.B [redacted] ALLERGIES: NKA noted ?Mark 8-25-05 1035 Use Second Date 8/25/05	DIAGNOSIS (If Chg'd) L R ADD hernia Motrin 200mg II po BID x 1 month PRN Ø heavy lifting > 15# x 6 month ☐ GENERIC SUBSTITUTION IS NOT PERMITTED Hay Crnp
NAME: STRICKLAND, WILLIE #226537 D.O.B [redacted] ALLERGIES: NKA Noted KC 7-21 Use First Date 7/21/05	DIAGNOSIS BB Prof. 6 x 6 month Cont wearing hernia truss x 6 months RTC PRN ☐ GENERIC SUBSTITUTION IS NOT PERMITTED Hay C CRNP

MEDICAL RECORDS COPY

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PRISON HEALTH SERVICES INCORPORATED

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PHYSICIANS' ORDERS

NAME: Strickland Willie
#226537
D.O.B. [redacted]
ALLERGIES: NKDA
Use Last Date 7/18/05
7/18/05 noted 5130 JW

DIAGNOSIS (If Chg'd)
BBP x 4 days.
V.O. Dr. Rayapati / JW

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Strickland, Willie
#226537
D.O.B. [redacted]
ALLERGIES: NKDA
Use Fourth Date / /
noted 1600 J Alexander RN 2/22/05

DIAGNOSIS (If Chg'd)
Truss – 6 mo
RTC 6 mo for FU

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Strickland, Willie
#226537
D.O.B. [redacted]
ALLERGIES: NKDA
Use Third Date 6/18/04
Noted B. Lisher RN 6-17-04 1230

DIAGNOSIS (If Chg'd)
Surgery Consult for RIH.

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Strickland, Willie
#226537
D.O.B. [redacted]
ALLERGIES: NKDA
Use Second Date 6/3/04
noted 6/3/04

DIAGNOSIS (If Chg'd)
lay in profile 6 mo

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Strickland, Willie
#226537
D.O.B. [redacted]
ALLERGIES: NKDA
Date 5/17/04
Noted G. Johnson RN 5-17-04 1450

DIAGNOSIS
Truss – RIH – X 6 wks

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY

Date/Time	Inmate's Name: Strickland Willie D.O.B.: / /
8-25-05	wt 190, T 98.8, R 18, P 68, O2 sat 98%, B/P 120/70
810	S/O hernia lower groin (Right side) painful
	3 [illegible] for [illegible] x 18 months [illegible]
	[illegible] USS [illegible] Ambulates [illegible] [illegible]
	ABD soft flat Hernia reducible [illegible] truss
	on as directed. denies [illegible]
	BS x 4 swelling masses noted
A	RL ABD hernia easily reducable [illegible]
P/R	Cont to wear truss
	[illegible] lifting > 15 # x 6 month
	[illegible] Safety [illegible] work/play
	RTC PRN Motrin 200mg [illegible] po BID x 1 month PRN
	[signature]

PHS
PRISON HEALTH SERVICES INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Strickland, Willie 226537 D.O.B.: [redacted]
2-22-05/1037	Wt. 193 # BP 110/70 P 76 R 18 T 99.2 – c/o hernia,
	pre-existing problem — [signature]
	(O) RIH – very small
	reducible – easily
	im – Exaggerating
	NT
	A RIH – im is using some
	reducible device – ? scrotal
	P may use Truss — support
	(E) do not strain – unduly
	[signature]
7-21-05/1115	190# – 99.8 – 110/58 – 80 – 18 – req. bottom bunk
	profile — [signature]
	31 WM for C/O as above c̄ Hx of (R) inguinal hernia
	x 2 yrs denies ↑ in size or pain no pull
	NMD US) N4x3 [illegible]
	ABD soft NT (R) Lower ABD NKDA
	⊖ swelling · BS + x4 hernia
	very small non detectable wearing hernia
	A (R) inguinal hernia truss today
	P cont hernia truss x 12 month
	(E) BB Profile x 12 month
	Report any ↑ size or N/V/D or pain asap
	RTC PRN [signature]

30111 (5/85)

...mplete Both Sides Before Using Another S...t

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Date/Time	Inmate's Name: Strickland, Willie 226531 D.O.B.: [redacted]
6/3/04	Wt. 190 B/P 120/66 P 74 R 16 T 98
	(S) Hernia
	(O) has small RIH -
	Reducible - NT -
	has BBB/ Truss -
	Abd soft, NT,
	No palpable masses
	NL - BS -
	Other Exam - NL.
	(A) RIH - Small
	(P) Lay in profile -
	[signature]
6-14-04/1055	Wt 193 B/P 106/74 P 70 R 18 T 99.2 - C/o hernia
	C. Hunter, LPN
	C/O Hernia (RIH - small - reducible
	(S) diagnosed 5/17/04
	(O) on standing a small RIH - palpable that disappears on supine position - NT - Benign - ~~dig~~ diagnosed a month ago - Hernia site - seems normal size -
	No significant dilation of (R) inguinal ring
	The rest of the exam was unremarkable -
	The letters from ~~the~~ IM, to HSA, and Warden noted
	(A) Small RIH
	on profiles - Truss not at provided - 2° shortage
	(P) ~~to~~ IM wants surgery - of supply, will soon will provide -
	Will write a surgery consult for approval
	[signature]

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INCORPORATED

PROGRESS NOTES

Date/Time	Inmate's Name: Strickland, Willie #226537 D.O.B.: [redacted]
5-7-04/1030	Wt 189.5 B/p 100/60 P 61 R16 T 98.6 - c/o ® abd. pain
	x 1 week ———— C. Hunter, LPN
	Wants BBB
	O) Abd NT Soft BS - NL .
	(A) Normal Exam
	P) denied BBB
	[signature]
5/17/04	Pain Rt groin area
1035	Wt 191lbs P-76 R-18 T98.8 Pulse ox 98% BP 122/60
S)	O)
	Some Swelling Comes at 6pm. in R groin area.
	now Some Reproducible tenderness and
	pubic pain, with out any Erythema and
	Swelling no Swelling now.
	other Exam - NL, Cough Reflex ⊗
	Hernial Sites NL.
	(A) - ? prodromal RIH
	? mild musculo skeletal pain
	Malingering for BBB
	P) Come and Show when Swelling Seen
	[signature]

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PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

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Print Name: Willie L. Strickland Date of Request: 8-23-05
ID # 226537 Date of Birth: [redacted] Location: 10-B 37B
Nature of problem or request: Pre-existing hernia- Injured myself obeying a direct order from DOC. I'm in a great deal of pain. This is my last attempt to get the surgery before I pursue legal action. I've been hurting about 20 mos. To wit 42 USC 1983.

Willie Strickland 226537
Signature

DO NOT WRITE BELOW THIS LINE

Date: 8/24/05
Time: 2:15 AM (PM)
Allergies: NKDA

RECEIVED
Date: 8/24/05
Time: 11:45
Receiving Nurse Intials DS

(FB) 8/25/05

O2 sat = 98%

(S)ubjective: I'm still hurting. They gave me a hernia brace. I just want to get the surgery over with. I still have 3 1/2 yrs. to do.

(O)bjective (V/S): T: 98.8 P: 59 R: BP: 112/74 WT: 187
w/ amb. to HCU c steady gait - A/O x 4 - C/O pain 8-9 from hernia. States when he 1st got truss it helped but it doesn't help any more.

(A)ssessment:
Alt. in comfort. (note: Pre-existing - $3.00 fee.)

(P)lan: appt. with Ms. Floyd, CRNP 8/25/05 - 8:00 AM

Refer to: ~~MD~~/PA (CRNP) Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on-call notified: Yes ( ) No ( )

Willie Strickland

[signature] Williams, RN
SIGNATURE AND TITLE

PHS
PRISON HEALTH SERVICES INCORPORATED

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PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Willie Strickland Date of Request: 7-17-05
ID # 226537 Date of Birth: [redacted] Location: 9-B 30T
Nature of problem or request: Renew bottom rack profile.
for preexisting condition "Hernia"

Willie Strickland
Signature

DO NOT WRITE BELOW THIS LINE

Date: 7/18/05
Time: 1220 AM (PM)
Allergies: NKDA

RECEIVED
Date: 7-18-05
Time: 12:30 DS
Receiving Nurse Intials

(S)ubjective: Need a bottom bunk profile because when I raise my leg my hernia pops out. They moved me to a top bunk on Sat. and I have a problem getting up and down. PAN 6/10

(O)bjective (V/S): T: 99.8 P: 80 R: 18 BP: 128/70 WT: #196
W/M Amb. to HCU steady gait - A/O X 4 -

(A)ssessment: Potential for/Risk for injury.

(P)lan: ① Refer to HCU 7/21/05 - appt. with Ms. Floyd, CLK (8:00 Am) ② BBP X 4 days.

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE (X) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

Willie Strickland

SIGNATURE AND TITLE

PRISON HEALTH SERVICES INCORPORATED

INFIRMARY NURSING PROGRESS NOTES

Date/Time	
04-08-05 0930	Annual physical completed. TB skin test given 5 difficulty. Tolerated procedure well. — J. Hueca, LP

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC
Strickland, Willie	226031	[redacted]	W/M	VCF

PHS-MD-70049

Complete Both Sides Before Using Another Sheet

PHS
PRISON HEALTH SERVICES INCORPORATED

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PRISON HEALTH SERVICES
SICK CALL REQUEST

Print Name: Willie Strickland Date of Request: 5-14-04
ID # 226537 Date of Birth: [redacted] Location: 3-Dorm
Nature of problem or request: Pain in right of stomach beside groin area

Willie Strickland
Signature

DO NOT WRITE BELOW THIS LINE

Date: 5/14/04
Time: 1945 AM PM
Allergies: NKA

RECEIVED
Date: 5-14-04
Time: 12:30
Receiving Nurse Intials DS

(S)ubjective: "I need some thing done about my right side and abd pain"

(O)bjective (V/S): T: 98.8 P: 78 R: 22 BP: 114/80 WT: 190
C/O right side abd pain and pain in groin area @ times, no swelling or redness noted

(A)ssessment:
Complt and alert

(P)lan: See Dr Rayapati
5-17-04 @ 10am

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE (X) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Willie Strickland Date of Request: 5-5-04
ID # 226537 Date of Birth: [redacted] Location: 3-Dorm 79-T
Nature of problem or request: Severe abdominal pain on right side

~~FOR PROFESSIONAL USE ONLY~~
CONFIDENTIAL RECORD
NOT TO BE PHOTO COPIED

Willie Strickland 226537
Signature

DO NOT WRITE BELOW THIS LINE

Date: 5/6/04
Time: 8:00 AM (PM)
Allergies: NKA

RECEIVED
Date: 5-6-04
Time: 12:30
Receiving Nurse Intials DS

(S)ubjective: Started hurting about a week ago but it keep getting worse.

(O)bjective (V/S): T: 99 P: 80 R: 20 BP: 110/70 WT: 190
No extreme pain when pressure applied, Normal, Tenderness, Redness Swelling
temp.

(A)ssessment: Gall Bladder.

(P)lan: Refer to Dr. Karpati Friday Am 8:00am. 5-7-04

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

PHS
PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Willie Strickland Date of Request: 4-1-04
ID # ______ Date of Birth: [redacted] Location: 3 dorm
Nature of problem or request: Flu. Sore throat fever knees Ankles

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NOT TO BE PHOTOCOPIED
Willie Strickland 226537
Signature

DO NOT WRITE BELOW THIS LINE

Date: 4/2/04
Time: 6:55 AM PM
Allergies: NKDA

RECEIVED
Date: 4-2-04
Time: 1:00
Receiving Nurse Intials DS

(S)ubjective: I have chills, my body is aching, running nose, sore throat

(O)bjective Wt 190# T 99.6 P 72 R 18 B/P 122/76
WM alert et oriented x3. Skin warm, dry. Nasal congestion noted. Reports cough. c/o general body aches

(A)ssessment:
alteration in comfort

(P)lan: CTM i PO BID
Sudafed 30mg ii PO BID
Guaifenesin 600mg PO BID
Tylenol 500mg ii PO BID
x 5 days
Instructed to increase H2O intake

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE
Check One: ROUTINE ( ) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

[signature]
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF1000 7/95

NAPHCARE
NURSE'S NOTES

DATE	TIME	
1-29-03	1655	Inmate rec'd, intake complete; instr to RTC
		to HCU on 1/30 @ 0800 for MH appt. [signature]
3/23/04	1045	P- annual Physical done - TB
		shot given —— [signature]
3/23/04	1130	White patch noted to (R) inner cheek. Stated
		history of chewing tobacco. Placed name on dental
		referral list. B- Lithe RN ——
2/24/05		Inmate summitted a request c/o hernia
		Was seen by MD on 2/22. Spoke
		c̄ MD on 2/24 in ref. to inmate
		complaint + request for referral. ——
		N Burks, RN

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NAME- LAST	FIRST	MIDDLE	AIS#
Strickland,	Willie		226537

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1–29
Motrin 200mg ii PO BID x 30d Msf lord CRNP/An 8-25-05 – 9-25-05	3am 3pm	→

MEDICATIONS HOUR 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR THROUGH

Physician

Telephone No.

Alt. Physician

Alt. Telephone

Medical Record No. 226530

Allergies

Rehabilitative Potential

Diagnosis Strickland Willie

Medicaid Number

Medicare Number

Complete Entries Checked:

By: Title: Date:

PATIENT Strickland Willie

PATIENT CODE 226530

ROOM NO

BED

FACILITY CODE

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1-29
Motrin 600 mg PO TID x 3 days 5-10-04 ——— 5-13-04 Dr Rayapati / [signature]	3A 9A 3P	7 a a a L 7 a a a L 7 a a a L

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NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR — THROUGH May 2004

Physician: Rayapati

Alt. Physician

Telephone No.

Alt. Telephone

Medical Record No

Allergies: NKDA

Rehabilitative Potential

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked: By: [signature] Title: [signature] Date: 5-10-04

PATIENT: Strickland, Willie

PATIENT CODE: 226537

ROOM NO

BED

FACILITY CODE: VCF

MEDICATION ADMINISTRATION RECORD

STDT01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
CTM - PO BID x 5 days 4-2-04 — 4-7-04 Dr Rayapati / [signature]	3A 3P	→	→	7 (3P: RD)					←	←	←																				
Sudafed 30mg ii PO BID x 5d 4-2-04 — 4-7-04 Dr Rayapati / [signature]	3A 3P	→	→	7 (3P: RD)					←	←	←																				
Humabid 600mg PO BID x 5d 4-2-04 — 4-7-04 Dr Rayapati / [signature]	3A 3P	→	→	7 (3P: RD)					←	←	←																				
Tylenol 500mg ii PO BID x 5d 4-2-04 — 4-7-04 Dr Rayapati / [signature]	3A 3P	→	→	7 (3P: RD)					←	←	←																				

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NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR: THROUGH: April 2004

Physician: Rayapati

Alt. Physician:

Telephone No.:

Alt. Telephone:

Medical Record No:

Allergies: NKDA

Rehabilitative Potential:

Diagnosis:

Medicaid Number:

Medicare Number:

Complete Entries Checked: By: [signature] Title: [signature] Date: 4-2-04

PATIENT: ~~Terry, Andre~~ Strickland, Willie

PATIENT CODE: ~~207276~~ 226537

ROOM NO.:

BED:

FACILITY CO: VCF

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

RECEIVED FEB 28 2005

DEMOGRAPHICS

Site Name & Number: VENTRESS-0845

Site Phone #: 334-7758178

Site Fax #: 334-775-8178

Patient Name: (Last, First,): Strickland Willie

Alias: (Last, First,)

Inmate #: 226537

SS Number: ___-___-____

Date: (mm/dd/yy): 2.25.05

Date of Birth: (mm/dd/yy): [redacted]

PHS Custody Date: (mm/dd/yy): __/__/__

Potential Release Date: (mm/dd/yy): __/__/__

Will there be a charge? ☐ Yes ☐ No

Sex: ☑ Male ☐ Female

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr Rayapati

Facility Medical Director Signature and Date:

Samuel Rayapati MD

☐ Service meets criteria for "approval via protocol"

History of Illness/Injury/Symptoms with Date of Onset:

Small RU # - with no significant sac easily Reducible

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DIA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy): __/__/__

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other: ____

Results of a complaint directed physical examination:

P/E - Examination. Reveals no significant change - from the past.

Specialist referred to:

Type of Consultation, Treatment, Procedure or Surgery:

Dr Whyte

Previous treatment and response (including medications):

Now prescribed TRUSS-

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You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

☐ Offsite Service Recommended and Authorized

Z-1 reducable → Truss

Date resubmitted: __/__/__

Regional Medical Director Signature, printed name and date required:

Will Mosier, MD 3/1/05

Do not write below this line. For Clinical and Corporate Data Entry ONLY.

Cert Type:

Med Class:

UR Auth #:

Pay 2-28-05

UM Referral review form 2-05-2004

UTILIZATION M AGEMENT REFERRAL REVIE FORM

Form n... be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: VENTRESS-0845

Patient Name: (Last, First) Strickland Willie

Date: (mm/dd/yy) 2.25.05

Site Phone # 334-7758178

Alias: (Last, First)

Date of Birth: (mm/dd/yy) [redacted]

Site Fax # 334-775-8178

Inmate # 226537

PHS Custody Date: (mm/dd/yy) ___/___/___

Will there be a charge? ☐ Yes ☐ No

Sex ☑ Male ☐ Female

SS Number ___-___-___

Potential Release Date: (mm/dd/yy) ___/___/___

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dental

Dr Rayapati

Facility Medical Director Signaure and Date:

Samuel Rayapati MD

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☑ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other:

Specialist referred to:

Type of Consultation, Treatment, Procedure or Surgery:

Dr Whyte

History of illness/injury/symptoms with Date of Onset:

Small Rt # - with No Significant Sac easily Reducible

Results of a complaint directed physical examination:

P/E - Examination Reveals no significant changes from the past

Previous treatment and response (including medications):

Now Prescribed - TRUSS

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You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information. Date resubmitted: ___/___/___

Regional Medical Director Signature, printed name and date required:

___/___/___ (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

UR Auth #:

fax 2-28-05

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

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DEMOGRAPHICS

Site Name & Number:	Patient Name: (Last, First)	Date: (mm/dd/yy)
VENTRESS-0845	Stinnett, Landville	06/14/04
Site Phone #	**Alias: (Last, First)**	**Date of Birth: (mm/dd/yy)**
334-775-3178		[redacted]
Site Fax #	**Inmate #**	**PHS Custody Date: (mm/dd/yy)**
334-775-3179	226537	01/21/03
Will there be a charge? ☐ Yes ☐ No	**Sex** ☐ Male ☐ Female	**SS Number** [redacted]	**Potential Release Date: (mm/dd/yy)** 12/28/09

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☑ Physician ☐ NP, PA ☐ Dentist

Dr. Samuel Raysoft

Facility Medical Director Signature and Date:

Samuel Raysoft M.D.

☐ Service meets criteria for "approval via protocol"

Place a check mark (√) in the Service Type requested (one only) and complete additional applicable fields.

☑ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: ____ ☐ Other:

Specialist referred to: Surgery

Type of Consultation, Treatment, Procedure or Surgery:

Eval for Surgery of a Small RIH - Benign and reducible

History of Illness/injury/symptoms with Date of Onset:

a month ago a small RIH - easily reducible, only visible on long standing and easily reduced on supine position degrees

Results of a complaint directed physical examination:

Small RIH - easily reducible Non-Tender - with no Signs of Acut obstruction of Right inguinal ring - No other Complications

Previous treatment and response (including medications):

Will Soon attempt will be supplied - But it states he will be more Comfortable with Surgery

H Has BBB - and lay in profile

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized

☑ Alternative Treatment Plan (explain here): IH reducable, conservative RX

☑ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

Date resubmitted: ___/___/___ Flex in 2010

Regional Medical Director Signature, printed name and date required: MOSCA 6.16.04 (mm/dd/yy)

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	UR Auth #:

UTILIZATION [illegible] NAGEMENT REFERRAL REV [illegible] W FORM

PHS

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS

Site Name & Number:	Patient Name: (Last, First,)	Date: (mm/dd/yy)
VENTRESS-0845	Strickland Willie	06/14/04
Site Phone #	**Alias: (Last, First,)**	**Date of Birth: (mm/dd/yy)**
334-7758178		[redacted]
Site Fax #	**Inmate #**	**PHS Custody Date: (mm/dd/yy)**
334-775-8178	226537	01/21/03
Will there be a charge? ☐ Yes ☐ No / **Sex** ☐ Male ☐ Female	**SS Number** [redacted]	**Potential Release Date: (mm/dd/yy)** 12/8/07

Responsible party: ☐ PHS ☐ Auto Ins. ☐ Health Ins.(Excludes Medicare/Medicaid Managed Care alternative plans) ☐ Other, be specific (Excludes Medicare and Medicaid):_____

CLINICAL DATA

Requesting Provider: ☒ Physician ☐ NP, PA ☐ Dental

Dr. Samuel Rayapati

Facility Medical Director Signaure and Date:

Samuel Rayapati M.D

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☐ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) ___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy ☐ Chemotherapy

Number of Visits/Treatments: _____ ☐ Other:_____

Specialist referred to: Surgery

Type of Consultation, Treatment, Procedure or Surgery:

Eval for Surgery of a Small RIH - Benign and reducible.

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Small RIH - easily reducible Non-Tender - with no signs Cant obstruction of Right inguinal ring - No other Complications

Previous treatment and response (including medications):

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He has BBB - and lay in profile

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form

☐ Pertinent Documents have been attached and faxed.

*****For security and safety, please do not inform patient of possible follow-up appointments*****

FOR PROFESSIONAL USE ONLY
CONFIDENTIAL RECORD
NOT TO BE PHOTO COPIED

UM DETERMINATION: ☐ Offsite Service Recommended and Authorized

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

Date resubmitted: ___/___/___

☐ Resubmitted with requested information

Returned Denied 6-16-04

Regional Medical Director Signature, printed name and date required:

___/___/___ (mm/dd/yy)

Signed 6-16-04

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:	Med Class:	UR Auth #:

PRISON HEALTH SERVICES INCORPORATED

PATIENT CONSENT AND AUTHORIZATION FOR DENTAL TREATMENT

Patient Name: Strickland, Willie BCDC#: 226537

1. I agree to having dental X-Rays taken of my teeth and jaws in order to determine my dental problems.

2. I have had a treatment plan explained to me, including alternatives or the recommendation of no treatment.

3. I consent to the use of local anesthetics or other medications and that there may be side effects, including allergic reactions and this has been explained to me.

4. I have had the opportunity to ask questions which have been answered to my satisfaction.

5. I understand there is no guarantee of success or permanence of the treatment.

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Willie Strickland
Patient's Signature

4-12-05
Date

W. E. Shirley
Dentist's Signature

4-12-05
Date

PRISON HEALTH SERVICES INCORPORATED

PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: Willie Strickland Date of Request: 12-20-04
ID # 226537 Date of Birth: [redacted] Location: 3-Dorm 77-B
Nature of problem or request: Bad toothache - needs pulling or fixing

Willie Strickland
Signature

DO NOT WRITE BELOW THIS LINE

Date: 12/23/04
Time: 1025 (AM) PM
Allergies: NKDA

RECEIVED
Date: 12-20-04
Time: 1215
Receiving Nurse Intials DS

(S)ubjective: I need fillings put back in my teeth

(O)bjective **(V/S):** T: P: R: BP: WT:
Teeth partly broken off on upper right side

(A)ssessment:

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(P)lan: Watch for name on newsletter for dental appt

Refer to: MD/PA Mental Health (Dental) Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE (✓) EMERGENCY ( )
If Emergency was PHS supervisor notified: Yes ( ) No ( )
Was MD/PA on call notified: Yes ( ) No ( )

R. Thompkins DA
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE
YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

DENTAL RECORD TREATMENT

Services Rendered

Date	Tooth #	Diagnosis	Treatment	Initials	Class
4/01/04			N/S dental appointment	R.T.	
12-23-04			dental Screening	R.T.	
4-12-05	3,9	caries	DO amalgam #3 DFL #9 composite resin	WEL	

PATIENT LAST NAME	FIRST	MIDDLE	DOB	R/S	ID NO
Strickland,	Willie		[redacted]	W/M	226537

PHS-MD-70022